**Direct Access to Housing (DAH) Clinical Referral Form**

In order to refer your client to Direct Access to Housing (DAH), please fill out this Clinical Referral Form (CRF) electronically. We use the information in this CRF to find the best possible placement for each client. DAH units vary in size, amenities, accessibility, and onsite support services. **Please include** **as much detailed information as possible** in order to help the DAH Access and Referral Team (DART) make a determination that best fits your client’s needs. Some questions are of a sensitive nature.

Please complete all sections. **Incomplete referrals will not be accepted and will be returned to you for more information**. If you need to leave a section blank, please address the reason in the comments section.

**Program Eligibility:**

To be eligible for DAH, clients must:

* + Be currently homeless and a resident of San Francisco
  + Be “extremely low-income,” defined by the US Department of Housing and Urban Development
  + Agree to pay a portion of their monthly income in rent via third party rent payment provider
  + Have a mental health diagnosis, substance abuse diagnosis, and/or complex medical needs

**Submitting the CRF:**

* Clinical Referral Forms must be saved in Word format and emailed to [**DAH@sfdph.org**](mailto:DAH@sfdph.org)**. Please do not fill the form out by hand and scan or fax it.**
* If outside the DPH/UC system, you must obtain a signed release of information from the client and submit it with the CRF.
  + Do not include identifying information in the email subject line or in the email body.
  + Documents must be password protected; passwords should be sent in a separate email.
  + Do not send referrals from a personal email account.
* **You must submit a scanned copy of the client’s government issued photo ID** **with this Clinical Referral Form**. Failure to produce identification documents, or to include a time-limited plan to obtain ID documents, will result in a denial of the referral under most circumstances.
* Each referral will be evaluated for eligibility. If your client is eligible and appropriate for the program, your client will be added to the DAH pool. You will receive written communication from DART regarding your client’s status within 20 business days.
* You are welcome to re-apply for your client if the circumstances leading to a DAH program denial have significantly changed, leading you to believe that the client might now be eligible.

**Please Note:**

* If an available and appropriate unit for your client is identified, DART will contact you to complete a **building-specific DAH application** with your client. You will need to submit a copy of the client’s Social Security Card and income verification. It is strongly encouraged that you begin working with your client now to obtain these documents. Failure to produce the documents in the timeframe allotted may result in a withdrawal of the offer.
* You and your agency are expected to assist your client with obtaining required documentation, attending interviews, and transitioning into the DAH unit.
* DART will not share your client’s clinical information with Property Management. Clinical information may be shared with Support Services staff, as necessary and appropriate.

If you have questions about filling out this CRF, contact DART: (DART Administrator) [laura.jessup@sfgov.org](mailto:laura.jessup@sfgov.org)

415-554-2828 or (DART Clinical Coordinator) [dah@sfdph.org](mailto:dah@sfdph.org)

**Client name as it appears on ID**

**Last Name**:       **First Name**:

**AKAs**

**Last Name(s)**:       **First Name(s)**:

**SSN**:        No SSN **DOB**: [Please click here to enter a date]

**Client is part of the following programs:**

Mental Health Services Act (MHSA) (Must provide proof of MHSA authorization from BHS at time of referral.)

Certificate of Preference (COP) Holder (Must have proof of COP from the Mayor’s Office on Housing and Community Development COP staff.)

**Referent Information**:

Name:

Title:

Agency:

Email:       Phone: (   ) -     -

Date of referral: [click here] Date you began working with this client: [click here]

**Alternate contact:**

Name:

Title:

Agency:

Email:       Phone: (   ) -     -

**What kind of government issued photo identification does your client have?**

Government issued photo identification is necessary for property management to complete background checks and confirm tenant identity.

State ID  Passport  VISA or consulate ID  None

\* Please include a scanned copy of the government issued photo identification with this referral. DAH can accept referrals for clients who are unable to provide government issued photo ID only in extreme circumstances.

**Is your client is a US citizen?**

Yes  No

\* If no, please note: most DAH sites do not require applicant to be a US citizen, but some do. Documentation verifying the client’s citizenship or naturalization is required at those sites.

**Has your client served in the military?**

Yes  No

**Language**:

Speaks/reads English  Monolingual, not English

\* If Monolingual, not English, please select language(s) spoken:

Spanish  French  Cantonese Korean Vietnamese  Russian  Other:

**Ethnicity:** (select one)

Hispanic/Latino  Other (Non-Hispanic/Latino) Don’t KnowRefused

**Primary Race:** (select one)

American Indian or Alaskan Native  Asian  Black or African American

Native Hawaiian or Other Pacific Islander  White  Other  Don’t Know  Refused

**Secondary Race (Optional):** (select one)

American Indian or Alaskan Native  Asian  Black or African American

Native Hawaiian or Other Pacific Islander  White  Other  Don’t Know  Refused

**What sex was your client assigned at birth?** (select one)

Male  Female

**Which best describes your client’s gender identification?** (select one)

Male  Female  M to F  F to M  Transgender  Other:

**What are your client’s preferred pronouns?** (optional)

he, him, his  she, her, hers  they, them, theirs  Other:

**Client Income**

**Please report total monthly income client receives from all sources**:

Total Monthly Income: $

**Income Source(s):** (check all that apply)

Social Security  Supplemental Security Income  CAAP  CAPI  CALM  Employment

Other (     )

**I have discussed third party rent payment enrollment with my client; client agrees to third party rent payment if housed.**

Yes  No

\* If no, please note: DAH participants are required to pay a portion of their monthly income toward rent via an approved third party rent payment provider.

**Physical Functioning and Locomotion**

**Please select your client’s ability to perform the following tasks on their own:**

**Housework**—How ordinary work around the house is performed (e.g. doing dishes, dusting, making beds, tidying up, laundry)

Independent  Some help  Full help  By others  Activity did not occur

**Shopping**—How shopping is performed for food and household items (e.g. selecting items, managing money)

Independent  Some help  Full help  By others  Activity did not occur

**Does your client currently receive In Home Support Services?**  Yes  No  Will enroll

If yes, for how many hours are they eligible?

**Primary Modes of Locomotion**

**Indoors** (select one)

No Assistive Device  Cane  Walker/Crutch  Manual Wheelchair  Electric Wheelchair

Activity did not occur (regardless of ability)

**Outdoors** (select one)

No Assistive Device  Cane  Walker/Crutch  Manual Wheelchair  Electric Wheelchair

Activity did not occur (regardless of ability)

**Stair Climbing** (select one)

In the last 3 days how client went up and down stairs (e.g. single or multiple steps, using handrail as needed)

Up and down stairs without help  Up and down stairs with help  Unable to go up and down stairs

**Do you anticipate your client will need an assistive device in the near future?**  Yes  No

**Has your client fallen in the past year?**  Yes  No

If yes, approximately how many times?

**Transportation**— How client travels by vehicle (e.g. gets to places beyond walking distance)

Independent  Some help  Full help  By others  Activity did not occur

**Does your client currently use Paratransit?**  Yes  No  Will apply

**Criminal Justice History**

**Please describe your client’s criminal justice history to the best of your knowledge and ability** (select all that apply)

No criminal justice involvement

History of arrests, *not* related to violence

If yes, please explain circumstances and give dates:

History of arrests, related to violence

If yes, please explain circumstances and give dates:

History of felony conviction

If yes, please explain circumstances and give dates:

Registered Sex Offender (RSO)

If yes, please explain circumstances and give dates:

**Housing History**

**Client’s living situation currently** (select one):

Sleeping outside, encampment or vehicle Location(s):

Couch surfing Location(s):

Jail / Incarceration Name of facility:

Board and Care Name of facility:

Emergency / Domestic Violence Shelter Name of facility:

Emergency Voucher / Stabilization Unit Location(s):

Inpatient unit / ADU Name of facility:

Skilled Nursing Facility Name of facility: ­­­­­­­­­­­­­­­­­­­­­­­­­­­

Transitional Housing or treatment facility Name of facility: ­­­­­­­­­­­­­­­­­­­­­­­­­­­

Projected discharge date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­   -    -

**Client’s living situation over the past year** (check all that apply):

Sleeping outside, encampment or vehicle Location(s):

Couch surfing Location(s):

Jail / Incarceration Name of facility:

Board and Care Name of facility:

Emergency / Domestic Violence Shelter Name of facility:

Emergency Voucher / Stabilization Unit Location(s):

Inpatient unit / ADU Name of facility:

Skilled Nursing Facility Name of facility: ­­­­­­­­­­­­­­­­­­­­­­­­­­­

Transitional Housing or treatment facility Name of facility: ­­­­­­­­­­­­­­­­­­­­­­­­­­­

Projected discharge date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­   -    -

**Which of the following best describes your client’s homelessness situation**:

Homeless for less than 1 month  Homeless between 1–12 months  Homeless for more than 1 year

**Has your client had 4 or more episodes of homelessness in the last 3 years**?

No  Yes

If yes, do these episodes add to more than 12 months?

No  Yes

**When did your client first become homeless?**  [Please click here to enter a date]

**What is the approximate lifetime length of homelessness your client has experienced?**      (years)      (months)

**Please enter a thorough narrative of your client’s homeless history, including dates, locations, and as much detail as possible**:

**Medical History and Medical Diagnoses** (*Please add details at the end of the section)*

**Does your client have a primary care provider** **with whom they are engaged?**

Yes Name of provider:       Clinic/hospital:

No

**If no, has client been referred to primary care provider?**

Yes Name of provider:       Clinic/hospital:

No

**Please check all chronic medical conditions your client has**:

Congestive heart failure  Cardiac arrhythmias  Valvular disease

Pulmonary circulation disorders  Peripheral vascular disorders  Hypertension

Paralysis  Neurodegenerative disorders  Cognitive decline

Diabetes, uncomplicated  Diabetes, complicated  Chronic pulmonary disease

Chronic Kidney Disease  Acute Kidney Injury  Cirrhosis

Renal failure  Liver disease  Peptic ulcer disease, no bleeding

Pressure Ulcers/Decubitus Ulcer (healed)  Pressure Ulcers/Decubitus Ulcer (unhealed) Stage:

AIDS  HIV  Metastatic cancer

Solid tumor without metastasis  Rheumatoid arthritis/collagen vascular diseases  Hypothyroidism

Coagulopathy  Anemia  Fluid and electrolyte disorders

Obesity  Weight loss  Alcohol abuse

Psychosis  Depression  Drug abuse

**Which of the following best describes your client’s medical situation** (check only one):

No health complaints, client appears well

Temporary medical problem (*e.g*. injection, wound, cast, splint)

Chronic, but stable medical condition – Describe:

Chronic, unstable medical condition – Describe:

Untreated chronic or terminal condition that is *worsening* (Advancing AIDS, worsening diabetes, worsening cancer)

**Does your client have symptoms with no explanation** (Weight loss, swelling of limbs, open & untreated wound, recurrent chest pain, chronic cough, shortness of breath, unexplained cognitive impairment)?

No

Yes If yes, explain:

**Does your client have an obvious *physical* problem that is not being cared for?**

No

Yes If yes, explain:

**Approximately how often has your client gone to the Emergency Department in the past 12 months** (select one)?

None in the past 12 months  Less than 3 ED visits in the past 12 months

3–5 ED visits in the past 12 months  6–8 ED visits in the past 12 months

8 or more ED visits in the past 12 months  Unknown

**Approximately how many times has your client been an inpatient in an acute hospital in the past 12 months** (select one)?

None in the past 12 months  1 in-patient stay in the past 12 months

2–4 in-patient stays in the past 12 months  4 or more in-patient stays in the past 12 months

Unknown

**Approximately how many days total has your client been an inpatient in the past 12 months?**

**How many days has your client been in a skilled nursing facility in the past 12 months** (select one)?

None in the past 12 months  Less than a month

1 month to 6 months  6 months to a year

Every day in the past year  Unknown

**Please describe your client’s medical diagnoses, history, and condition as thoroughly as possible in your own words**:

**Mental Health History and Diagnoses** (*Please add details at the end of the section)*

**Does your client have a mental health provider** **with whom they are engaged**?

Yes Name of provider:       Clinic/hospital:

No

**If no, has client been referred to mental health provider?**

Yes Name of provider:       Clinic/hospital:

No

**Please check all mental health diagnoses your client has**:

Schizophrenia  Schizoaffective disorder  Bipolar affective disorder Type:

Major depression  Post-traumatic stress disorder (PTSD)  Hoarding/Cluttering

Personality disorder Specify traits:

Other Specify:

Comments:

**Which of the following best describes your client’s mental health situation** (select one):

No mental health issues  Reports feeling down about life circumstances or situation (no diagnosis)

History of severe mental illness

If yes,  Symptoms are being adequately treated  Only mild impairment to functioning (*e.g.* Major depressive

disorder, bi-polar, schizophrenia, severe personality disorder)

Severe mental illness; symptoms presently impair functioning

If yes,  In treatment  Untreated

Severe mental illness, or symptoms & behavior of mental illness; symptoms markedly impair functioning

If yes,  In treatment  Untreated  Poor response to treatment

**Mental Health symptoms are known to worsen with consumption alcohol or substances**:

No  Yes

**Please describe your client’s mental health history, diagnoses, and condition as thoroughly as possible in your own words**:

**Alcohol and Substance Use History** (*Please add details at the end of the section)*

**Which substances does your client currently use?**

Alcohol (any use at all)     Alcohol (to intoxication)     Heroin     Methadone

Other Opiates/Analgesics     Barbiturates     Sedatives/Hypnotics/Tranquilizers

Cocaine     Amphetamines     Cannabis     Hallucinogens

**Which substances does your client have a history using?**

Alcohol (any use at all)     Alcohol (to intoxication)     Heroin     Methadone

Other Opiates/Analgesics     Barbiturates     Sedatives/Hypnotics/Tranquilizers

Cocaine     Amphetamines     Cannabis     Hallucinogens

**Which of the following best describes your client’s current substance use patterns?**

N/A

Strictly social use; no impact on functioning

Sporadic used of substance; able to meet basic needs

Use of substances affecting ability to meet basic needs; some trouble making progress in goals

Use of substance impacting ability to gain/maintain functioning in many areas; high relapse potential

Active addiction markedly impacting functioning and meeting basic needs (food, housing, appointments)

**Please describe your client’s history of substance use as thoroughly as possible in your own words**:

**Medication Management**

**Client is able to manage prescribed medications by themselves** (including obtaining refills on time, taking medications as prescribed, maintaining compliance with prescribed medications)

Not at all: Misses all doses without supervision, unable to obtain refills, does not take medications as prescribed

Fairly well: Misses some doses without supervision, sometimes unable to obtain refills on their own

Well: Takes most medications as directed, minimal prompting needed, makes good use of medi-sets

Very well: Takes all medications as directed, no prompting or assistance needed, gets refills on time

Exceptionally well: Never misses a dose of medications, highly responsible

**Please describe any injectable medications your client takes and their adherence:**

**Would your client benefit from having an on-site nurse hold and dispense their medications?** Describe why:

**Is your client able to dress wounds and change dressings as directed if given supplies?** Describe:

**Functional Ability**

**Food, clothing, hygiene**

Generally able to use services to get food, clothing; take care of hygiene

Some trouble staying on top of basic needs/hygiene but can usually care for self

Able to get needs met with assistance

Has not been able to get needs met, but no history of resisting offers of assistance in recent past

Has not been able to get needs met, and has refused or resisted offers of help in recent past

**Survival Skills** (pedestrian safety, getting injured, networking and accessing social services)

Strong survival skills; capable of networking and self-advocacy

Medium survival skills; needs assistance recognizing unsafe behaviors

Lacks street smarts; doesn’t understand unsafe behaviors

Poor survival skills; often in dangerous situations

Clear disregard for personal safety

**Attention, self-care, organizational skills**

Good attention span; adequate self-care; Able to keep track of appointments

Occasionally disorganized; may require minimal prompting

Sometimes disorganized; occasional confusion with regard to orientation

Disorganized or disoriented; Poor awareness of surroundings

Highly confused; disorientation in reference to time, place and/or person

**Communication, interpersonal skills**

Strong and organized communication; able to communicate clearly with case manager or provider

Occasional trouble communicating needs

Frequent difficulty in communicating

Unable or unwilling to communicate effectively

Significant inability communicating with others or refuses to talk with case manager

**Coping skills, problematic behavior, violence** (select all that apply)

Client has a history of physical violence

Client has a history of verbal aggression

Client is quick to anger and/or emotionally labile

Please describe:

**Strengths and Challenges** (Being as realistic as possible will help your client be successful in supportive housing)

Your client’s strengths:

Activities your client enjoys:

Your client’s primary challenges:

**Other notes about your client that DART should consider**:

**------------------------------------------------ Admin use only (DART) ------------------------------------------------**

Date reviewed by DART:    -    -       Accepted  Pending Information  Denied

Date DART notified Case Manager of status:    -    -

Notes:

Severity score:     Chronically homeless  Yes  No

Utilization Summary: Days inpatient     ED episodes     SNF days